

Background - What is the issue?

Cervical and breast cancer are significant health problems for ethnocultural minority women in North America, who have higher rates of mortality and lower rates of utilization of screening tests than average - in fact, the rate of cancer of the cervix among the immigrant population in Canada is estimated at six times greater than the average.¹⁾ The numbers of minority women diagnosed with breast cancer are expected to rise over next ten years as result of changes in lifestyle and environmental factors.²⁾ It has been estimated that early detection could reduce breast cancer deaths by 30%³⁾ and cervical cancer deaths by 90%.⁴⁾ There are, however, many barriers to cervical screening⁵⁾ Breast cancer screening also is underutilized by minority women⁶⁾. Anecdotal evidence suggests that Hispanic women greatly underuse cancer screening facilities in Ottawa-Carleton, consistent with research findings that this community lacks knowledge of and has limited access to many preventive health services.⁷⁾

The 'lay health promoter' approach, based on principles of community capacity-building and adult education, was developed as a relatively inexpensive and efficient way of reaching out to underserved populations in rural and poor urban areas of many countries; and for those populations to increase their own capacity to achieve and maintain good health. Although Hispanics are in the top five linguistic minority groups in Ottawa-Carleton, and a quickly-growing newcomer community (estimated at 25,000 - 35,000);⁸⁾ they are very geographically dispersed, lack ethno-specific services, include many isolated women with limited economic and educational opportunities, and have many unmet needs. Hispanic women have taken the initiative to begin building community capacity around health issues and laid the foundation for a lay health promoter approach, through LAZO. The model is innovative in combining two approaches: a) increasing access by having the lay health promoters' cultural, health, and linguistic skills act as bridges for other, more isolated women; and b) simultaneously increasing the readiness of the health-service providing community to meet growing demand, through partnership and participation as active community advisors who will help identify barriers, develop strategies, and transfer knowledge to practice. Although health promotion programs with multicultural groups and communities have been funded across Canada, evaluations are rare; few programs have a research component, resources to conduct evaluations of replicated models, or disseminate information - especially programs with a community capacity

building approach.⁹⁾ Primary and preventive health care providers in the region, therefore, are interested to assess whether this model can effectively be applied to increase access and use of cancer screening and preventive health services, with the Hispanic community, and also with other hard-to-reach, underserved populations (other linguistic/ethnoracial minorities; women with disabilities).

What is current knowledge?

Despite the known value of cancer screening, a significant number of women, including socially and economically disadvantaged women and those from minority ethnoracial groups, do not participate in optimal screening programs.^{2),5),10),11),12),13)} Recent literature suggests that Hispanic women in North America less likely to participate in optimal breast and cervical cancer screening than women of other racial and ethnic groups.^{13),14),15),16),17),18)} Other studies mention lower rates of lifetime mammography, clinical breast examination, monthly performance of BSE for Hispanic than non-Hispanic women.¹⁹⁾ World Health Organization figures indicate low use of optimal cervical screening in Latin American countries, from which the great majority of the Hispanic population in Canada is drawn. Although mass screening for cervical cancer has reduced invasive cancer rates in North America, Hispanic women, especially those from linguistically isolated households, tend to not participate in early detection.^{14),20)} As a consequence, Hispanic women may be presenting with more advanced stages of the disease¹⁶⁾ and be at greater risk than women from other ethnic minority groups.

There are many cultural, psychological, demographic and health care system barriers to cancer screening among minority women.¹³⁾ Women from different racial and ethnic groups face different barriers.³⁾ In Canada, lack of knowledge about how cancer is perceived by cultural sub-groups acts as a barrier to developing effective cancer control measures. Although Ontario's breast screening programs desire recruitment of women from ethnic and cultural minorities, to date there has been little coordinated effort between volunteer, minority community, and health professional sectors. The complex and problematic relationships between cancer control and multiculturalism, is described in another study "cancer control efforts must become more accountable to a Canadian society that is defined by its multiracial, multilingual and culturally diverse characteristics."²¹⁾ As another example: The majority of cancer information distributed in Ontario by the

Canadian Cancer Society is available only in English or French;²²⁾ many women from the nearly 100 other ethnocultural groups in Ontario experience a basic inequity in accessing cancer information in a language they can easily understand.²¹⁾

Despite this need, there appear to be few Canadian research studies focusing on minority women and cervical/breast health (although a number of generally short-term health promotion activities have been funded, e.g., in Toronto, Hamilton, and Ottawa). Questions remain, including: what are the specific barriers that minority women face in relation to breast and cancer screening in Canada? What is the best way to increase early detection in high risk women for whom culture and/or language pose a barrier?²³⁾

Most research on Hispanic women comes from outside Canada, where health care access would be an additional factor. Nevertheless, there is sufficient indication that multiple barriers exist that extend beyond financial barriers, and that need to be explored in a Canadian setting. Factors influencing screening rates for Hispanic women include: socioeconomic status;^{13),18) 24),25),26),27)} education;^{11),18),24),27)} access to insured health care¹⁸⁾ cultural meanings and level of acculturation,^{17),26),28),29)} attitude towards traditional family structure;¹⁷⁾ support of spouse;³⁰⁾ place of birth;^{14),18)} facility in English;^{17),18),25)} having a regular, female source of care;³⁾ lack of information and misinformation about cancer;^{14),18), 27),28),29),26),31)} fear of pain from the test^{14),13)} embarrassment.^{14) 32)}

Within the diverse Hispanic community, socioeconomic, educational, and country-of-origin factors may also impact on cancer awareness and screening practices. For example, foreign-born Hispanics have been found to have more misconceptions about cancer than other Hispanics.¹⁴⁾ Age is another key dimension, and several studies note especially low compliance for older Hispanic women,³¹⁾ who may be least knowledgeable¹⁸⁾ and most benefit from culturally relevant strategies.¹⁵⁾ Access to, and attitudes of, primary care providers, including physicians, also influence screening behaviour in Hispanic women.^{11),33)}

In summary: There is an urgent need for innovative ways to increase screening in minority populations, especially women who are outside the 'mainstream'. Culture, age, acculturation, language, and socioeconomic factors need to be taken into account in developing health education

messages and interventions to reduce cancer risk with Hispanic women.³⁴⁾
³⁵⁾ ³⁶⁾ Multiple level interventions, including educational approaches directed to primary care professionals, in combination with a variety of other approaches to decrease barriers, may improve effectiveness of breast and cervical screening for certain groups of women.³²⁾ ³⁷⁾ A number of approaches are currently being implemented, generally in small-scale projects without a research component. These include non-traditional approaches and interventions that include social support;³⁸⁾ collaborative approaches involving different sectors of the community; and approaches based on capacity building, community development, and empowerment of women.⁷⁾ Capable communities are key to successful public health and health promotion interventions in the Ottawa-Carleton area.³⁹⁾ To increase success in serving Latino communities, organizations should integrate themselves into the community through outreach, recruitment and inclusion in decision making; structures to ensure communication and participation from community and health professionals are open and mixed.⁴⁰⁾

Source: Estable, A. and Meyer M.C., Proposal for Ontario Women's Health Council project, November 2000.

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